Report to the Legislature

Quarterly Child Fatality Report

RCW 74.13.640

July – September 2011

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Executive Summary

This is the Quarterly Child Fatality Report for July through September 2011 provided by the Department of Social and Health Services (DSHS) to the Washington State Legislature. RCW 74.13.640 requires DSHS to report on each child fatality review conducted by the department and provide a copy to the appropriate committees of the legislature:

> ***Child Fatality Review — Report***
>
> *(1)(a) The department shall conduct a child fatality review in the event of a fatality suspected to be caused by child abuse or neglect of any minor who is in the care of the department or a supervising agency or receiving services described in this chapter or who has been in the care of the department or a supervising agency or received services described in this chapter within one year preceding the minor's death.*
>
> *(b) The department shall consult with the office of the family and children's ombudsman to determine if a child fatality review should be conducted in any case in which it cannot be determined whether the child's death is the result of suspected child abuse or neglect.*
>
> *(c) The department shall ensure that the fatality review team is made up of individuals who had no previous involvement in the case, including individuals whose professional expertise is pertinent to the dynamics of the case.*
>
> *(d) Upon conclusion of a child fatality review required pursuant to this section, the department shall within one hundred eighty days following the fatality issue a report on the results of the review, unless an extension has been granted by the governor. A child fatality review report completed pursuant to this section is subject to public disclosure and must be posted on the public web site, except that confidential information may be redacted by the department consistent with the requirements of RCW 13.50.100, 68.50.105, 74.13.500 through 74.13.525, chapter 42.56 RCW, and other applicable state and federal laws.*
>
> *(2) In the event of a near fatality of a child who is in the care of or receiving services described in this chapter from the department or a supervising agency or who has been in the care of or received services described in this chapter from the department or a supervising agency within one year preceding the near fatality, the department shall promptly notify the office of the family and children's ombudsman. The department may conduct a review of the near fatality at its discretion or at the request of the office of the family and children's ombudsman.*

During the previous quarter, SHB 1105 was passed by the legislature and signed into law by Governor Gregoire. The revised child fatality statue (RCW 74.13) was effective during the 3rd quarter of 2011. The revised child fatality statute requires the department to conduct fatality reviews in cases where a child death is suspected to be caused by abuse or neglect. This eliminates the requirement to conduct formal reviews of accidental or natural deaths unrelated to abuse or neglect. The revised statute requires the department to consult with the Office of Family and Children's Ombudsman (OFCO) if it is not clear that the fatality was caused by abuse or neglect. The department can conduct reviews of near fatalities or serious injury cases at the discretion of the department or recommendation by OFCO. The new law gives the department access to autopsy and post mortem reports for the purpose of conducting child fatality reviews.

This report summarizes information from 12 completed reviews of fatalities that occurred in 2011. Regional child fatality review teams reviewed an additional 12 child fatalities not caused by child abuse or neglect, but as a result of accident or illness. In 2011, the child fatality statute was revised to require the Department to post only reviews conducted in child deaths that resulted from child abuse or neglect. The reports from child fatality reviews from non-abuse or neglect related fatalities are not posted on the public website and are not included in this quarterly report. However, this report includes analysis of data from those reports.

All prior Executive Child Fatality Review reports are found on the DSHS website: http://www.dshs.wa.gov/ca/pubs/fatalityreports.asp.

The reviews in this quarterly report include fatalities from each of the three regions[1].

Region	Number of Reports
1	7
2	4
3	1
Total Fatalities Reviewed During 3rd Quarter, 2011	12

This report includes Child Fatality Reviews conducted after a child died unexpectedly from any cause and manner, and the child had an open case or received services from the Children's Administration (CA) within 12 months of his/her death. Child Fatality Reviews consist of a review of the case file,

[1] DSHS implemented a reconfiguration of the regional boundaries in May 2011. The existing six regions were consolidated into three.

identification of practice, policy or system issues, recommendations, and development of a work plan, if applicable, to address any identified issues. A review team can be as few as two individuals (in cases where the death is clearly from a natural cause or accidental), to a larger multi-disciplinary committee where the child's death may have been the result of abuse and/or neglect by a parent or guardian.

Executive Child Fatality Reviews (ECFR) are conducted in cases where the child fatality is the result of apparent abuse or neglect and CA had an open, active case at the time of the child's death or the child received services from the department within 12 months of his/her death. In the Executive Child Fatality Review, members of the review committee are individuals who have not had any involvement in the case and represent areas of expertise that are pertinent to the case. The review committee members may include legislators or representatives from the Office of the Family and Children's Ombudsman.

The chart below provides the number of fatalities reported to CA, and the number of reviews completed and are pending for calendar year 2011. The number of pending reviews is subject to change if CA learns new information through reviewing the case. For example, CA may learn that the fatality was anticipated rather than unexpected, or there is additional CA history regarding the family under a different name or spelling.

Child Fatality Reviews for Calendar Year 2011			
Year	Total Fatalities Reported to Date Requiring a Review	Completed Fatality Reviews	Pending Fatality Reviews
2011	41	40	1

The numbering of the Child Fatality Reviews in this report begins with number 11-04. This indicates the fatality occurred in 2011 and is the fourth report completed during that calendar year. The number is assigned when the Child Fatality Review and report by the Child Protective Services Program Manager or practice consultant is completed. The reviews contained in these Quarterly Child Fatality Reports are a summary of the actual report submitted by each region.

Notable Findings

Based on the data collected and analyzed from the 12 child deaths reviewed between July and September 2011, the following were notable findings:

- One child fatality occurred when the youth was residing in a facility licensed by the Division of Licensed Resources. This fatality was not the result of abuse or neglect by the caregivers.
- Two fatalities occurred in Department of Early Learning (DEL) facilities.

- Children 11 months or younger accounted for approximately 75% (9) of the 12 fatalities reviewed and 5 of the 9 fatalities of children under 1 year of age were female.
- Of the 12 child fatalities reviewed, 58% (7) were males and 42% (5) were females.
- Of the 12 child fatalities reviewed, 50% (9) of the children were identified as white, 17% (3) were Native American, 6% (1) was Hispanic, 17% (3) were identified as African American, 10% (2) were identified as Asian/Pacific Islander. Some of the children are identified as being of more than one race or ethnicity.
- Natural and accidental deaths, as classified by the medical examiner or coroner, accounted for approximately 75% (9)) of the total deaths. The manner of death of the remaining cases was as follows: 17% (2) were due to unknown/undetermined causes, and 8% (1) were the result of suicides. There were no deaths as a result of homicide.
- Of the 12 child fatalities reviewed, 11 had prior contact with Children's Administration (CA). One review was conducted on a child fatality that occurred at a licensed child care facility with no prior history. Seventy-five percent (75%) of the child fatalities reviewed had between zero and four prior intakes and 25% had between five and twenty prior intakes.
- Due to the small sample of cases reviewed, no statistical analysis was conducted to determine relationships between variables.

Table 1.1

3rd Quarter 2011, Child Fatalities by Age and Gender						
Age	**Number of Males**	**% of Males**	**Number of Females**	**% of Females**	**Age Totals**	**% of Total**
<1	4	57%	5	100%	9	75%
1-3 Years	1	14%	0	-	1	8%
4-6 Years	0	-	0	-	0	-
7-12 Years	0	-	0	-	0	-
13-16 Years	2	29%	0	-	2	17%
17-18 Years	0	-	0	-	0	-
Totals	7	100%	5	100%	12	100%

N=12 Total number of child fatalities for the quarter.

Table 1.2

3rd Quarter 2011, Child Fatalities by Race	
Black or African American	3
Native American	3
Asian/Pacific Islander	2
Hispanic	1
White	9
Unknown	-
Total Some children may be in more than one category	**18**

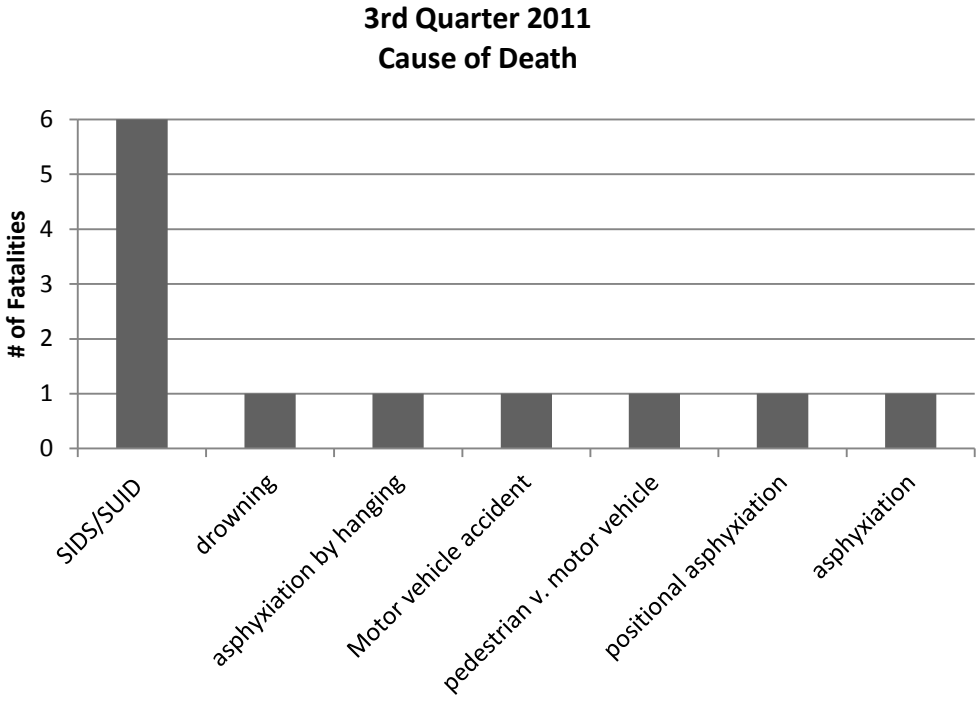
*Some children may be in more than one category.

Table 1.3

3rd Quarter 2011, Child Fatalities by Manner of Death	
Accident	5
Homicide (3rd party)	0
Homicide by Abuse	0
Natural/Medical	5
Suicide	1
Unknown/Undetermined	1
Total	**12**

N=12 Total number of child fatalities for the quarter.

Table 1.4



N=12 Total number of child fatalities for the quarter.

Table 1.5

3rd Quarter 2011, Number of Reviewed Fatalities by Prior Intakes						
Manner of Death	**0 Prior Intakes**	**1-4 Prior Intakes**	**5-9 Prior Intakes**	**10-14 Prior Intakes**	**15-24 Prior Intakes**	**25+ Prior Intakes**
Accident	1	1	1	-	1	-
Homicide (3rd party)	-	-	-	-	-	-
Homicide	-	-	-	-	-	-
Natural/Medical	-	4	1	-	-	-
Suicide	-	1	-	-	-	-
Unknown/ Undetermined	-	2	-	-	-	-

N=12 Total number of child fatalities for the quarter.

Summary of the Recommendations

Of the 12 child fatalities reviewed between July and September 2011, 8 (67%) identified issues and recommendations during the child fatality review process. Issues and recommendations from fatality reviews impact policy, practice and systems associated with CA. At the conclusion of every case that receives a full team review, the team decides whether any recommendations should result from issues identified during the review of the case. In most instances where the death was categorized as being preventable, some recommendations were made.

Issues and recommendations that were cited during the child fatality reviews completed during the quarter fell into the following categories:

3rd Quarter 2011, Issues & Recommendations	
Contract issues	0
Policy issues	0
Practice issues	8
Quality social work	3
System issues	6
Total	**17**

In two cases, issues and recommendations were made regarding thorough CPS investigations; and in two other cases issues were raised about timely documentation by social workers. In these four cases, these issues were addressed through action at the local office level. Safe sleep education was an issue raised by one review team. Poor communication with service providers and delays in a referral to a service provider were identified issues in two separate cases. Each was addressed at the local level at the time of the review. A review team questioned the lack of reporting by mandated reporters in one case, but did not identify a recommendation from this issue.

Issues involving supervision of young children were identified in one case. These issues were identified in a fatality review of a child death occurring in a Department of Early Learning (DEL) licensed facility.

An issue identified by one fatality review team addressed covering funeral expenses for a dependent youth. The team recommended CA create a protocol to determine when CA will cover the funeral expenses for children who die when a case is open.